Rhode Island HEALTH
CONTINUITY OF CARE FORM

Instructions

Fill in all applicable information on pages 1 - 4 (pages 1 - 2 only for patients being discharged home with no services). Use N/A in sections that do not apply to the patient. Include the patient's full name on all pages.

PAGE 1:

Discharging Agency: A facility/agency may elect to add their own Facility/Agency Name and Logo to this slot on the form or may hand print their Facility/Agency Name each time they fill out this form

Patient Name: Include the patient's full name (Addressograph may be used in right upper corner if available and clearly legible)

Home Address: Include the address at which the patient resided prior to this admission regardless of whether they are returning to that address upon discharge

Being Discharged to: Insert the place the patient is being discharged to

Address: Include the address that the patient will be going to upon discharge if different from the patient's home address

Phone: Include the telephone number at the address the patient is being discharged to

Referral to: Insert the name of the facility, physician or the name of the visiting nurse agency that the patient is being referred to for post discharge care

Phone: The telephone number where the above can be contacted

Contact Person @ Discharging Facility: The person who should be contacted regarding questions concerning this patient's stay at your facility

Phone/Beeper #: The telephone number/beeper number of the contact person listed above

*If the patient is being transferred to another facility the **Patient demographic/registration sheet**, the **last 7 days of Medication sheets and IV fluid sheets** and copy of **Most recent lab results MUST** be attached and sent with the Continuity of Care Form. Check the boxes next to those items you are sending with the patient.

TO BE FILLED OUT BY PHYSICIAN:

Principal Diagnosis Of This Admission: The diagnosis(es) the patient was being treated for in this facility

Surgery This Admission: List all surgeries performed on this patient that took place during this admission

Date: List the dates of the above surgeries

Other Active Medical Problems: List all of the patient's other current/active diagnoses

Allergies, list and describe reactions: List all known allergies and describe what happens during an allergic reaction to each

Active Infection(s) this admission and site: List all infections that the patient had during this admission and the site of each infection

Physician treatments/orders - Please specify number and frequency: List all orders for treatment and care post discharge, include the number of times and frequency of each, as well as any additional comments in the space provided. Be sure to include the patient's diet on the line provided. Check the appropriate box to indicate the patient's condition at discharge (improved or unchanged). Also, check the box beside each of the following services/treatments that apply: Skilled Home Nursing Care, Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy.

New prescriptions: check the appropriate box to indicate if prescriptions were or were not provided for new medications

List ALL medication(s) to be taken POST discharge: List all orders for medication to be given post discharge, be sure to include route, dosage and frequency for each medication

Instructions Until Next Doctor Visit: Check off the boxes that indicate whether the patient is allowed, needs supervision, or is not allowed to perform each activity listed during the time period from discharge to their next physician visit

Attending Physician's Signature: and **Date**: The signature of the attending physician completing/verifying the physician orders/treatments, medications, and instructions on page one of this form and the date completed

Discharge Summary dictated by: The name of the physician who dictated the discharge summary for this patient

Physician(s) who will follow this patient after discharge: and **Phone**: Print the name of the physician(s) who will follow the patient POST discharge and that physician's telephone number

Physician notified: Check the box to indicate whether the physician(s) listed above has been notified of the patient's discharge from your facility

PAGE 2:

Discharging Agency: A facility/agency may elect to add there own Facility/Agency Name and Logo to this slot on the form or may hand print their Facility/Agency Name each time they fill out this form.

Patient Name: Include the patient's full name (Addressograph may be used in right upper corner if available and clearly legible)

Does the patient have an Advanced Directive? Includes Durable Power of Attorney for Health Care, Living Will

No: Check this box if the patient does not have any advanced directives
Yes: Check this box if the patient does have an advanced directive
Full: Check this box if the patient is a full code
DNR: Check this box if the patient has a "Do Not Resuscitate" order while in your facility
CMO: Check this box if the patient has an order for "Comfort Measures Only" while in your facility

IMMUNIZATION(S) this admission:

INFLUENZA: Check this box if the patient had the Influenza Vaccine while in your facility
PNEUMOVAX: Check this box if the patient had the Pneumonia Vaccine while in your facility

TUBERCULIN STATUS - if known:

Negative: Check this box if the patient had a negative result from PPD or chest X-ray in the past 3 months

Positive: Check this box if the patient has ever had a positive PPD or chest X-ray

Unknown: Check this box if you do not know the tuberculin status of this patient

DISCHARGE TO:

Home – No Services: Check this box if the patient is returning home but will not receive any home or out patient services

Home care/services: Check this box if the patient is returning home and will receive home or out patient services

REHAB: Check this box if the patient will receive rehab services post discharge

Nursing Home: Check this box if the patient is being discharged to a nursing home

Other: Check this box if the patient is being discharged to another facility/agency and specify which type on the line provided

Active Infections: If the patient has/or has had MRSA, VRE, and/or C-Diff infections fill in the appropriate box(es):

Positive Culture: Check the box if the patient has colonized this bacteria

Active Infection: Check the box if the patient currently has the infection

Date Resolved: Write the date the infection resolved in the corresponding box

Agency: Insert the name of the agency that the patient is being referred to for post discharge care/services

Phone: The telephone number of the above agency

Visit(s) scheduled for: the date(s) and time(s) of any schedule visits with the above agency

Information given to patient on discharge: Check the boxes that indicate the information given to the patient on discharge and complete the remainder of this section to include when to call the physician, any wound instructions and follow–up appointments (if known), include appropriate phone numbers.

MEDICATIONS:

1. If the patient is being discharged to home: List the medications** the patient is/will be taking after discharge including the dose, frequency, time last given and the time the next dose is due. **Check the box for either **Pre-admission** (medication the patient was on prior to admission) or **new** (medication ordered since this admission) Also check the yes column if the patient should continue taking the medication after discharge and check the no column if they should not.
2. If the patient it being transferred to another facility: Attach a copy of the most current medication sheet(s). The sheet(s) should be reviewed for accuracy and signed by the discharging nurse.

Date completed: The date the nurse completed the information on page 2

Comment: Use this space to included any additional information that needs to be communicated to the patient/parent/guardian ***Be sure to check the appropriate box to indicate if prescriptions were or were not provided for new medications**

Nurse's signature: and **Patient signature** or **parent/guardian – name(s)/signature**: After reviewing the instructions with the patient and/or parent/guardian, page 2 should be signed by the nurse and the patient and/or parent/guardian

Phone: Include telephone number where nurse who signed page 2 can be reached

Interpreter(s) name: If an interpreter was used in reviewing this page with the patient and/or parent/guardian, print each interpreter's name on the line provided

PAGE 3: PHYSICAL & FUNCTIONAL STATUS – Nurse Form

Patient Name: Include the patient's full name
Date: The date the nurse completed the information on page 3

Activities of Daily Living on discharge Day: On the day the patient is being discharged from your facility put the appropriate code for how the patient actually self performed the following activities:

SELF PERFORMANCE CODES:

0 = Independent: No help or staff oversight provided during activity
1 = Supervision: Oversight, encouragement or cueing provided during activity
2 = Limited Assistance: Patient highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight bearing assistance
3 = Extensive Assistance: Weight bearing support was provided but patient performed/assisted in part of the activity
4 = Total Dependence: Full staff performance of the activity, no participation from the patient in all aspects of the ADL definition
5 = Activity did not occur: The ADL activity was not performed by the staff or the patient

ADL DEFINITIONS:

Transfer: How the patient moves between surfaces – i.e., to/from bed to chair, wheel chair or standing position (exclude from this definition movement to/from bath or toilet).
Dressing: How the patient puts on, fastens, and takes off all items of clothing.
Toileting: How the patient uses the toilet room, commode, bedpan or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.
Personal hygiene: How the patient maintains personal hygiene including: combing hair, brushing teeth, applying makeup and washing/drying face, hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.
Walking: How the patient walks from place to place.
Eating: How the patient eats and drinks, regardless of skill. Includes intake of nourishment by other means (i.e., tube feeding, total parenteral nutrition).
Bathing: How the patient takes a full-body bath/shower or sponge bath and transfers in/out of tub/shower. Exclude washing of back and hair.

Mobility: **Upper Extremities**: Check "Normal" if the patient has full range of motion on both sides, Check "Impaired" if the patient has limitations on one or both sides (Include fingers, wrists, and shoulders)
Lower Extremities: Check "Normal" if the patient has full range of motion on both sides, Check "Impaired" if the patient has limitations on one or both sides (Include hips, knees, and ankles)

Amputee: Check this box if the patient has any amputations and include location of amputation on the line provided

Prosthesis use: Check this box if the patient uses any prostheses and include type of prosthesis in the space provided

Equipment needed on discharge: Include all equipment the patient will need for ADL performance/support post discharge (i.e. standard walker, rolling walker, left lower leg prosthesis, weighted utensils)

Stage and location on diagram of all decubitus ulcers: Include all pressure ulcers the patient currently has and stage as follows:

Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
Stage 3: A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.
Stage 4: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Other wounds present: Check **No** if the patient's skin is intact with no other lesions or wounds. Check **Yes** to include all other open areas and describe size and appearance on the lines provided.

BOWEL AND BLADDER ASSESSMENT:

Bowel/Bladder Program (specify): If the patient is on a bowel or bladder program, include the name of that program (i.e. bowel retraining, bladder retraining, prompted voiding, habit training, scheduled toileting)

Put a checkmark for the best response under the column for Bladder and again under the column for Bowel:

BLADDER (choose one response):
Continent: Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.)
Occasionally incontinent: incontinent episodes occur two or more times per week but not daily
Frequently incontinent: incontinent episodes tend to occur daily, but has some bladder control present
Incontinent: Has inadequate bladder control, incontinence occurs multiple times daily

BOWEL (choose one response):
Continent: Complete control (including control achieved by care that involves habit training, reminders, etc.)
Occasionally incontinent: incontinent episodes occur once a week
Frequently incontinent: incontinent episodes occur 2-3 times per week
Incontinent: Has inadequate bowel control, incontinence occurs all (or almost all) of the time

Date of last BM: record the date the patient last had a bowel movement

Ostomy (type/size): include type of ostomy (i.e. colostomy, ileostomy, nephrostomy) and size of appliance

Foley type and balloon size: if the patient has a foley, record the type of catheter inserted and size of the balloon

Date foley changed: record the date the foley was last changed (or date of insertion if not changed)

Dialysis (*type*): Check this box if the patient is receiving dialysis and record the type of dialysis (hemodialysis, peritoneal, etc.)

VITAL SIGNS

Height: Record the patient's most recent height
Weight: Record the patient's most recent weight
Pulse range: Record the patient's pulse range over the past week
Resp. range: Record the patient's respiration range over the past week
Temp: Record the patient's temperature range over the past week
Blood Pressure: Record the patient's blood pressure range over the past week
On Oxygen @: If the patient is receiving oxygen record the oxygen rate (liters per minute)
Pulse ox range: Record the patient's pulse ox range over the past week

Pain Score: Record the patient's pain level. 0 = no pain, 10 = worst possible pain. If your facility uses a different pain scale to measure pain, please convert your answer to scale of 0 – 10
Describe Pain: include location and intensity of pain as well as any contributing factors

COGNITIVE STATUS – Cognitive skills for daily decision making

How well does the patient make decisions about organizing the day? (Choose one response):

Independent: The patient's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values
Modified independence: The patient organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations
Moderately impaired: The patient's decisions were poor; the patient required reminders, cues, and supervision in planning, organizing, and correcting daily routines
Severely impaired: The patient never (or rarely) made decisions

Level of consciousness: Check only one response as they are listed below:

Alert
Drowsy but arousable with minor stimulation
Requires repeated stimulation to respond
Responds only with reflex motor or autonomic system
Effects or totally unresponsive

Mini Mental Health Examination: Check all that apply:

Patient is oriented to _____ person _____ place _____ year
Thought or speech organization is coherent
Maintains attention, not easily distracted
Short term memory okay – recalls 3 items after 5 minutes

COMMUNICATION

Primary Language: Record the language the patient primarily speaks or understands in the space provided. Is the patient able to **Understand**, **Speak**, **Read**, and/or **Write** in the primary language? Check all that apply.

Secondary Language: If the patient speaks/understands a language other than the primary language, record that language in the space provided. Is the patient able to **Understand**, **Speak**, **Read**, and/or **Write** in the secondary language? Check all that apply.

Aphasia: Check if the patient has **Expressive** Aphasia or **Receptive** Aphasia

Sign language use: Check **Yes** if the patient uses sign language, check **No** if patient does not

IMPAIRMENTS – HEARING/VISUAL

Auditory (with hearing appliance if the patient uses one) Check the appropriate box(es):

Hears adequately: The patient hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities

Minimal difficulty: The patient hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations

Intermittently impaired: Although hearing deficient, the patient compensates when the speaker adjusts tonal quality and speaks distinctly; or the patient can hear only when the speaker's face is clearly visible

Highly impaired: The patient hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

Has hearing device: Check this if patient uses a hearing device and specify type used in the space provided

Vision (with glasses/visual appliance if used - i.e. eyeglasses, contact lenses or a magnifying glass for close vision)

Sees adequately: The patient sees fine detail, including regular print in newspapers/books

Impaired: The patient sees large print, but not regular print in newspapers/books

Moderately impaired: The patient has limited vision, is not able to see newspaper headlines

Severely impaired: The patient has no vision, sees only light, colors or shapes; or eyes do not appear to follow objects (especially people walking by)

Uses visual device: Check this if patient uses a visual appliance and specify type of visual appliance used in the space provided

COMMENTS: Describe any deviation in the patient's physical and/or functional status not addressed in the nursing discharge summary or in the above information

Nurse signature, Title, Date, and Contact number: The nurse completing this section must sign and date it. Include the telephone number and extension where the nurse can be reached.

PAGE 4:

Patient's Name: Include the patient's full name

Nursing Discharge Summary: This summary should be a brief description of the patient's stay at your facility along with the reason for the referral or transfer. This section should be used to communicate pertinent specific details regarding patient needs/preferences that would enhance the continued care of the patient. Information regarding **IV** is important and should be completed as appropriate. Be sure to sign and date this section and include the telephone number of the unit where the nurse filling out this section can be reached.

Other Disciplines: All disciplines involved with the care of this patient should complete a summary of their interventions in the additional squares (use additional page 4 forms as needed). All sections should contain the discipline, signature and title of the person completing the section, the date and the telephone number where they can be reached.

PAGE 5:

The Continuity of Care Form: Consultation/Referral Form (page 5) is considered the "Short Form" and may be used in place of pages 1 - 4 when the patient is sent for consultation only or in the case of emergency when there is not time to fill out all 4 pages.

Patient Name: Include the patient's full name

Date Completed: The date the information on page 5 was completed

Attending Physician: and **Phone**: Print the name of the physician caring for the patient in your facility and that physician's telephone number

Responsible party: and **Phone**: Print the name of the patient's responsible party and their telephone number

Relationship: Include the relationship of the responsible party to the patient

Guardian: Check **Yes** if the responsible party is also the patient's legal guardian, check **No** if the responsible party is not the patient's legal guardian

POA: Check **Yes** if the responsible party is also the patient's Durable Power of Attorney, check **No** if the responsible party is not the patient's Durable Power of Attorney

Facility/Residence Address: Include the full name of your facility/residence and the full address

Agency Contact Person: and **Phone**: The person who should be contacted regarding questions concerning this patient and the telephone number of the contact person listed

Medicaid #: If the patient has a Medicaid number, include it on the line provided

Medicare #: If the patient has a Medicare number, include it on the line provided

Other Insurance: Include the name and member number for any other health insurance the patient has

Patient referred to: Include the name of the physician/agency/facility the patient is being referred to for consultation or acute care

Reason for visit/consult/transfer: Check the appropriate box to indicate the reason for this visit/consult/transfer and if this is for acute care, specify the problem on the line provided. If this is a consult/referral, include the name of the physician ordering the consult/referral

Does the patient have an Advanced Directive? Includes Durable Power of Attorney for Health Care, Living Will

No: Check this box if the patient does not have any advanced directives
Yes: Check this box if the patient does have an advanced directive
Full: Check this box if the patient is a full code
DNR: Check this box if the patient has a "Do Not Resuscitate" order while in your facility

Tuberculin Status - if known:

Negative: Check this box if the patient has had negative results from PPD or chest X-ray since being admitted to your facility
Positive: Check this box if the patient has had a positive PPD or chest X-ray
Unknown: Check this box if you do not know the tuberculin status of this patient

Active Infections: If the patient has/or has had MRSA, VRE, and/or C-Diff infections fill in the appropriate box(es):

Positive Culture: Check the box if the patient has colonized this bacteria
Active Infection: Check the box if the patient currently has the infection
Date Resolved: Write the date the infection resolved in the corresponding box
Prior History: Check the box if the patient has a history of this infection

*When using the Continuity of Care Form: Consultation/Referral Form (page 5), a copy of the patient **Demographic/Face Sheet**, **Advanced Directive, Diagnosis/Problem List, Medication Sheet(s),** and if applicable **Most recent X-ray and/or lab results MUST** be attached and sent with the Continuity of Care Form. Check the boxes next to those items you are sending with the patient.

DESCRIPTION OF PROBLEM: This section should contain the reason for the referral or transfer, along with a brief description of the patient's recent medical and functional status as it relates to the reason for the referral. This section should also be used to communicate pertinent specific details regarding the patient's symptoms and/or progress since the last visit/consult if applicable.

Expectation for situation: Check the box to indicate if this is a Long-term or Short-term problem

CONSULTATION NOTES: This section is to be filled out by the physician seeing the patient at this visit/consult. After completing the note, the physician should check the appropriate box(es) to indicate if there are any documents to be attached to the form (Additional Notes & Diagnosis, New Test Results, New Prescription(s)/Orders). The physician should also indicate if a follow-up visit is required and include the appointment date/time on the line provided.

*The completed Continuity of Care Form: Consultation/Referral Form (page 5) should be returned to the facility/residence with the patient at the end of the visit/consult with any necessary attached documents.